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ABSTRACT

Recent reports have documented how some parents choose to place their children in the child welfare or juvenile justice systems in order to obtain the mental health services that their children need. Senators Susan Collins and Joseph Lieberman of the Senate Committee on Governmental Affairs asked the General Accounting Office (GAO) to testify on: (1) the number and characteristics of children voluntarily placed in the child welfare and juvenile justice systems to receive mental health services, (2) the factors that influence such placements, and (3) promising state and local practices that may reduce the need for child welfare and juvenile justice placements. This testimony is based on the April 2003 report on the results of a study addressing these same objectives. For that report, the GAO surveyed state child welfare directors in all states and the District of Columbia and juvenile justice officials in 33 counties in the 17 states with the largest populations of children under age 18. Results of these surveys reveal that some parents, a variety of state and local officials, mental health service providers, caseworkers, and judges misunderstood the role and responsibilities of schools in implementing IDEA. For example, some parents and professionals misunderstood that IDEA gives all eligible children, including children with a mental illness, the right to a free appropriate education and parents did not know that they could appeal a school's decision about providing special education services. (Contains 14 references.) (GCP)

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Testimony

Before the Committee on Governmental Affairs, U.S. Senate

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CHILD WELFARE AND JUVENILE JUSTICE

Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services

Statement of Cornelia M. Ashby, Director
Education, Workforce, and Income Security Issues

ED 478 678

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Highlights

Highlights of GAO-03-865T, a testimony for the Committee on Governmental Affairs, United States Senate

CHILD WELARE AND JUVENILE JUSTICE

Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services

Why GAO Did This Study

Recent news articles in over 30 states and prominent mental health advocacy organizations have described the difficulty many parents have in accessing mental health services for their children. As these reports documented, some parents choose to place their children in the child welfare or juvenile justice systems in order to obtain the mental health services that their children need. Senators Susan Collins and Joseph Lieberman of the Senate Committee on Governmental Affairs asked GAO to testify on: (1) the number and characteristics of children voluntarily placed in the child welfare and juvenile justice systems to receive mental health services, (2) the factors that influence such placements, and (3) promising state and local practices that may reduce the need for child welfare and juvenile justice placements. This testimony is based on our April 2003 report on the results of a study addressing these same objectives. For that report, we surveyed state child welfare directors in all states and the District of Columbia and juvenile justice officials in 33 counties in the 17 states with the largest populations of children under age 18. We surveyed juvenile justice officials at the county level because of the decentralized nature of the juvenile justice system. We also researched laws and regulations and conducted site visits to 6 states.

www.gao.gov/cgi-bin/getrpt?GAO-03-865T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cornelia Ashby at (202) 512-8403 or ashbyc@gao.gov.

What GAO Found

Child welfare directors in 19 states and juvenile justice officials in 30 counties estimated that in fiscal year 2001 parents placed over 12,700 children into the child welfare or juvenile justice systems so that these children could receive mental health services. Nationwide, this number is likely higher because many state child welfare directors did not provide data and we had limited coverage of county juvenile justice officials. Although no agency tracks these children or maintains data on their characteristics, officials said most are male, adolescent, often have multiple problems, and many exhibit behaviors that threaten the safety of themselves and others.

Neither the child welfare nor the juvenile justice system was designed to serve children who have not been abused or neglected, or who have not committed a delinquent act. According to officials in the 6 states we visited, limitations of both public and private health insurance, inadequate supplies of some mental health services, difficulties accessing services through mental health agencies and schools, and difficulties meeting eligibility rules for services influence such placements. Despite guidance issued by the various federal agencies with responsibilities for serving children with mental illness, misunderstandings among state and local officials regarding the roles of the various agencies that provide such services pose additional challenges to parents seeking such services for their children.

Officials in the states we visited identified practices that they believe may reduce the need for some child welfare or juvenile justice placements. These included finding new ways to reduce the cost of or fund mental health services, bringing services into a single location to improve access, and expanding the array of available services. Few of these practices have been rigorously evaluated.

In a related report, we recommended that (1) the Secretary of Health and Human Services (HHS) and the Attorney General investigate the feasibility of tracking these children to identify the extent and outcomes of these placements, (2) the Secretaries of HHS and Education and the Attorney General develop an interagency working group to identify the causes of the misunderstandings and create an action plan to address those causes, and (3) the agencies continue to encourage states to evaluate the child mental health programs that states fund or initiate and that they determine the most effective means of disseminating the results of these and other available studies to state and local entities. In commenting on a draft of that report, Education, HHS, and the Department of Justice generally agreed with our findings but did not fully concur with the recommendations, particularly related to tracking the children. All three agencies said they would participate in any interagency working group that might be established based on our recommendation.

Madam Chairman and Members of the Committee:

Thank you for inviting me here today to discuss how federal agencies could do more to help states reduce the number of children placed in child welfare and juvenile justice systems solely to obtain mental health services. As recent news articles in over 30 states and prominent mental health advocacy organizations have reported, many parents have difficulty accessing mental health services for their children with severe mental illnesses.[1] In some cases, parents must choose to remove their children from their homes and seek alternative living arrangements by inappropriately placing them in the child welfare or juvenile justice system to obtain mental health services—two systems not designed to care for children solely because of their mental health needs.[2] Various federal laws require that state and local agencies provide services to mentally ill children in the most integrated setting appropriate to their needs; that is, children have a right to receive services in their communities unless their needs can only be met by the state in residential or institutional placements.

My testimony today will focus on three key issues: (1) the numbers and characteristics of children voluntarily placed in the child welfare and juvenile justice systems in order to receive mental health services, (2) the

[1]Federal agencies and states have varying definitions for children with serious emotional disturbances (SED). For example, the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) defines SED as a diagnosable mental disorder found in persons from birth to 18 years of age that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities. Because of these differences, we use the term "children with severe mental illness" to describe such children throughout this statement.

[2]Child welfare systems are designed to protect children who have been abused or neglected by, for example, placing children in foster care or providing family preservation services; and juvenile justice systems are designed to rehabilitate children who have committed criminal or delinquent acts or status offenses—that is, according to the Department of Justice (DOJ), behaviors that are law violations only if committed by juveniles—and to prevent such acts from occurring. Consequently, the goals of these systems and the background and training of their staff reflect these purposes. In addition, parents cannot voluntarily place their children in the juvenile justice system. Children are detained in this system as a result of their delinquent acts or status offenses. However, parents sometimes request that police arrest their children for behaviors that are related to or stem from their mental illness when they cannot obtain services through other means. In this statement, we use the term "placed" to refer both to children who have been voluntarily placed in the child welfare system and children who enter the juvenile justice system to receive mental health services. Because information was not available, we were not able to report on whether parents relinquished custody of their children to obtain the services.

factors that influence such placements, and (3) state and local practices that may reduce the need for some child welfare and juvenile justice placements. My comments are based on the findings from our April 2003 report, Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services (GAO-03-397, April 21, 2003). In conducting that study, we analyzed responses to our survey of state child welfare directors in all states and the District of Columbia and our survey of juvenile justice officials in 33 counties in the 17 states with the largest populations of children under age 18. We surveyed juvenile justice officials at the county level, rather than at the state level, because of the decentralized nature of the juvenile justice system. In addition, we interviewed officials of child-serving agencies,[3] caseworkers, and parents in 6 states (Arkansas, California, Kansas, Maryland, Minnesota, and New Jersey) and judges in each state we visited except Minnesota.[4] We also observed programs that state officials identified as model programs in those 6 states; interviewed key federal officials and national experts; and researched state laws and regulations regarding voluntary placement and relinquishment of parental rights.

In summary, state child welfare officials in 19 states and county juvenile justice officials in 30 counties estimated that in fiscal year 2001 parents in their jurisdictions placed over 12,700 children—mostly adolescent males—into the child welfare or juvenile justice systems so that these children could receive mental health services. Nationwide, this number is likely higher because 32 state child welfare officials, including officials of 5 states with the largest populations of children, did not provide us with data. However, officials in 11 of those states indicated that although they did not have an estimate to provide, such placements occurred in their state. Also, we surveyed juvenile justice officials in only 33 counties; 30 of which responded with an estimate. Although no federal or state agency tracks these children or maintains data on their characteristics, officials said most are male, adolescent, and often have multiple problems. Many exhibited behavior that threatened their safety and the safety of others. In addition, these officials said children who were placed came from families of all financial levels and that the seriousness of the child's illness strained the family's ability to function.

[3]Child-serving agencies include mental health, Medicaid and State Children's Health Insurance Program (SCHIP), juvenile justice, education, and child welfare.

[4]We did not interview judges in Minnesota primarily due to scheduling conflicts.

A variety of factors influenced whether parents placed their children in the child welfare and juvenile justice systems to receive mental health services for them; these included limitations in health insurance coverage, shortages of mental health services in some localities, difficulties in accessing services through mental health or education agencies, eligibility requirements for services provided by different agencies and programs, and misunderstandings among state and local officials and service providers regarding the responsibilities of various agencies to meet children's mental health needs. For example, despite guidance issued by various federal agencies with responsibilities for serving children, state and local officials' views of the roles of their own agency and other agencies, such as mental health, child welfare, education, and juvenile justice, showed that they misunderstood those roles and, therefore, could not effectively give parents complete and accurate information about available services their agency and other agencies could provide.

The state officials that we interviewed identified a range of practices in their states that they believe may help to prevent some child welfare and juvenile justice placements. These included finding new ways to reduce the cost of or to fund mental health services, bringing mental health services into a single location to improve access, and expanding the array of available services. However, the effectiveness of these practices is generally unknown because many were new, few were rigorously evaluated, and many served a small number of children or only children in specific locations.

To determine the extent to which children may be placed inappropriately in the child welfare and juvenile justice systems in order to obtain mental health services, we recommended in our April 2003 report that the Secretary of Health and Human Services (HHS) and the Attorney General investigate the feasibility of tracking these children to identify the extent and outcomes of these placements. To help reduce misunderstandings at the state and local level, we also recommended that the Secretaries of HHS and Education and the Attorney General develop an interagency working group to identify the causes of the misunderstandings and to create an action plan to address those causes. We further recommended that these agencies continue to encourage states to evaluate the child mental health programs that states fund or initiate and that the Secretaries of HHS and Education and the Attorney General determine the most effective means of disseminating the results of these and other available studies to state and local entities. In commenting on a draft of the report, the Department of Education, HHS, and DOJ generally agreed with our findings but did not fully concur with the recommendations. Education

said that it did not understand how tracking the children would increase the likelihood of progressive practices to provide children's mental health services and noted that no recommendations were made for increased grant spending to duplicate or disseminate the positive features of such practices. HHS said that asking the agencies to track this population of children in foster care does not address the larger point of the lack of mental health resources for families and communities and does not address the problems of the children or their parents. DOJ agreed that tracking should occur, but only in the short term, and said that HHS should take the lead in this activity. All three agencies said they would participate in any interagency working group that might be established based on our recommendation.

Background

As defined by the President's New Freedom Commission on Mental Health, the mental health system in the United States collectively refers to the full array of private and public programs for individuals with mental illness that deliver or pay for treatment and services. The federal government plays a major role in funding mental health services through public insurance—Medicaid and SCHIP—and grants to states and local agencies, and state and local governments play a major role in delivering services. Most families depend on private and public insurance to pay for mental health services because such services are expensive, although, as we discussed in a previous report, children may face certain limitations in coverage barriers depending on their type of coverage and where they live.[5]

At the federal level, several federal agencies—including HHS's SAMHSA, Centers for Medicare & Medicaid Services (CMS), and the Administration for Children and Families (ACF); DOJ's Office of Juvenile Justice and Delinquency Prevention (OJJDP); and Education's Office of Special Education and Rehabilitative Services (OSERS)—have a role in addressing the mental health needs of children. However, all have individual mandates, target different but often overlapping populations, and share responsibilities to varying degrees with state and county agencies. (See table 1.)

[5]U.S. General Accounting Office, *Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown*, GAO-02-813 (Washington, D.C.: Aug. 22, 2002).

Table 1: Characteristics of Key Agencies with Responsibilities for Mentally Ill Children

Department and agency	Key activities related to children's mental health	Statute	Population targeted and definition of mental illness
HHS (CMS)	Administers the Medicaid and SCHIP programs that provide health insurance coverage to certain low-income individuals and disabled children, including some children with severe mental illness. Awards research grants. Provides technical assistance to state agencies.	Title XIX of the Social Security Act	Certain low-income individuals and certain disabled individuals. Uses a clinical classification of diseases to identify children with a mental illness.
HHS (ACF)	Oversees the Adoption and Safe Families Act (ASFA) of 1997 that improves the safety of children and promotes adoption and permanent homes for children who need them and supports families. Administers Title IV-B of the Social Security Act that provides funds to states for services that protect the welfare of children. For example, these services address problems that may result in the abuse and neglect of children. The funds may also be used to provide services to families of children with a mental illness. Administers the Title IV-E Foster Care Funds Program that provides funds to states to partially cover the costs of room and board for eligible children from low-income families who are placed in approved out-of-home living arrangements. Maintains the Adoption and Foster Care Analysis and Reporting System (AFCARS), to which states report demographic data on children in foster care, including diagnoses of mental illness. Awards development, training, research, and demonstration grants. Disseminates research. Provides technical assistance.	Title IV, Part B and Part E of the Social Security Act ASFA	Children and families. Uses a clinical classification to identify children with a mental illness and accepts classifications used by individual states in identifying children with mental health needs.
Education (OSERS)	Monitors the implementation of the Individuals with Disabilities Education Act (IDEA). IDEA established the right of disabled children—including children with mental illness—to receive special education and related services, such as mental health services, designed to meet their unique needs and prepare them for employment and independent living when such services are needed for children to make adequate progress in school. IDEA requires schools to evaluate children who are referred for special education services and, if services are required, develop an individualized education program (IEP) that documents the type and intensity of services that will be provided. Funds formula and discretionary grants. Provides technical assistance. Disseminates research.	IDEA	Promotes improvement in educational results for infants, toddlers, and children with disabilities. Under IDEA, the term "child with a disability" means a child, who by reason of a physical or mental disability, needs special education and related services.

Department and agency	Key activities related to children's mental health	Statute	Population targeted and definition of mental illness
HHS (SAMHSA)	Provides funds to states and local entities to help them administer, support, or establish programs that specifically target the mental health needs of children and block grant funding that enables states to maintain and enhance mental health services. Sponsors the Systems of Care Initiative to help children and adolescents with serious mental illnesses and their families receive a variety of services from schools, community mental health centers, and social services organizations and facilitate coordination among these service providers. Awards formula and discretionary development and demonstration grants. Disseminates research. Provides technical assistance.	Public Health Service Act	Individuals with substance abuse problems, mental illness, or at risk of substance abuse and mental illness. Children served meet the following criteria: • age 0 to 18 and • have a diagnosed mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that results in impairment that substantially interferes with or limits the child's functioning in family, school, or community activities.
DOJ (OJJDP)	Helps oversee juvenile justice programs across the nation and supports states and local communities in their efforts to develop and implement effective and coordinated prevention and intervention programs. Helps improve the juvenile justice system's ability to protect public safety, hold offenders accountable, and provide mental health treatment and rehabilitative services. Funds formula and discretionary grants. Provides technical assistance. Disseminates research.	Juvenile Justice and Delinquency Prevention Act	Children who commit crimes or are delinquent and children at risk for delinquency. Accepts mental illness classifications used by states to identify children with mental health needs.

Source: GAO.

Note: Other agencies, such as HHS's Social Security Administration, DOJ's Division of Civil Rights, and HHS's and Education's Office for Civil Rights, also have responsibilities for children with disabilities, including children with a mental illness.

Federal law does not require parents to relinquish their parental rights to place their children with child welfare agencies. However, after children are in care for a specific period of time, the law requires that the court be involved to determine if termination of the parents' rights are in the best interest of the child. State laws addressing the ability of parents to place their children in child welfare systems vary across states. Nationwide, laws in 11 states allow parents to place children in child welfare systems on a voluntary basis in order to access mental health services for as long as necessary without relinquishing custody of the child to the state.[6] Child

[6]The 11 states are: Alaska, Colorado, Connecticut, Iowa, Maine, Minnesota, North Dakota, Oregon, Rhode Island, Wisconsin, and Vermont.

welfare directors in 8 other states and the District of Columbia advised us that their states do not allow parents to place children voluntarily in child welfare agencies to access such services.[7] Laws in the remaining states are generally silent regarding voluntary placements for mental health.

Federal agencies with responsibilities for children with mental illness support interagency collaboration at the federal and local level. For example, officials at SAMHSA are collaborating with officials at Education and OJJDP to improve mental health services for children with emotional and behavioral disorders who are at risk of violent behavior by developing and implementing a large grant program that targets these children. At the state and county level, a similar array of agencies provides or funds services for mentally ill children, and state and federal laws and policies often determine their roles and responsibilities. Importantly, federal agencies play a key role in funding research and evaluation studies and disseminating the findings of these efforts. For example, SAMSHA, OJJDP, and OSERS fund research and evaluation studies that target children with mental illness and disseminate the findings of these efforts, descriptions of promising practices, and other information through their clearinghouses, journals, and Web sites.

Despite their differences, programs run by agencies at all levels of government adhere to the principle of "least restrictive alternative." Under this principal, the state has the burden of demonstrating that state-funded out-of-home placements are necessary for the protection of the child or society. In 1999, the U.S. Supreme Court established this principle as a right for disabled children. In *Olmstead v L.C.*, the Court held that under Title II of the Americans with Disabilities Act, states may be required to serve people with disabilities in community settings when such placements can be reasonably accommodated.

Mental health treatment can be very expensive, and most families rely upon insurance to help cover the cost of these services. For example, one outpatient therapy session can cost more than $100, and residential treatment facilities, which provides 24 hours of care, 7 days a week, can cost $250,000 a year or more. Nationwide, about 87 percent of American children are covered by private or public health insurance plans. Private plans, such as employer-sponsored or individually purchased plans,

[7]The 8 states are: Florida, Georgia, Hawaii, Kansas, Missouri, Montana, New Hampshire, and Texas.

provide health insurance coverage to about 68 percent of American children, and public programs, such as Medicaid and SCHIP, provide health insurance coverage to about 19 percent.[8]

Most private health insurance plans offer different coverage for mental health services than for physical health services. To ensure more comparable coverage, the federal government passed the federal Mental Health Parity Act (MHPA) of 1996. MHPA prohibited certain employer-sponsored group plans from imposing annual or lifetime restrictions on mental health benefits that are lower than those imposed on other benefits. However, the act did not eliminate other restrictions and limitations on mental health coverage, such as limiting the number of treatments per year that are reimbursable. In addition, the law does not apply to plans sponsored by employers with 50 or fewer employees, group plans that experience an increase in plan claims costs of at least 1 percent because of compliance, and coverage sold in the individual market. According to the National Council of State Legislatures, as of November 2001, 46 states have passed mental health parity bills. Most of these laws meet or exceed the federal MHPA standard. However, the Employee Retirement Income Security Act of 1974 preempts states from directly regulating self-funded, employer-sponsored health plans; under such circumstances, states requirements usually do not apply.

For more than 30 years, Medicaid has provided comprehensive health insurance for children from low-income families. Although individual states determine many coverage, eligibility, and administrative details, the federal government sets certain requirements for state Medicaid programs. These requirements include coverage of screening and necessary treatment for children. Under Medicaid, states may apply for and receive approval from the federal government to waive certain provisions of the Medicaid statute in order to operate a specific program, change the benefits offered under Medicaid, or make comprehensive changes to their Medicaid or SCHIP programs. For example, states can use the Home and Community-Based Services (HCBS) (section 1915(c) of the Social Security Act) waiver to provide home and community-based long-term care services to targeted groups of individuals who would otherwise require care in a hospital, skilled nursing facility, or intermediate care facility. To receive the HCBS waiver, states must demonstrate that the cost of the

[8]U.S. General Accounting Office, *Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals*, GAO-03-191 (Washington, D.C.: Oct. 25, 2002).

services to be provided under the waiver is no more than the cost of institutionalized care plus any other Medicaid services provided to institutionalized individuals. Additional flexibility is available to states under the "Katie Beckett" option, which enables states to use federal Medicaid funds more flexibly to cover the costs of health care services in the home and community rather than just in institutional settings, regardless of the income and assets of the family.[9] States choosing this option provide Medicaid coverage for children under age 19 who meet certain standards for disability, would be eligible for Medicaid if they wer in an institution, and are receiving medical care at home that would be provided in an institution. Although family income and resources are not considered in determining eligibility for services under the Katie Beckett option, states can require families to contribute to the cost of the progra The Rehabilitation option allows states to provide optional Medicaid services such as psychiatric rehabilitation and other diagnostic, screenin and preventive services in nonmedical settings.

States are pursuing a variety of approaches for expanding public health insurance for uninsured children from low-income families by implementing SCHIP programs. States have three options in designing SCHIP programs. For example, 24 states implement SCHIP by expanding Medicaid programs to include children from low-income families with earnings too high to qualify for Medicaid. Fourteen have developed a separate or independent child health insurance program with benefits tha differ from those offered under Medicaid. Others use a combination of Medicaid and non-Medicaid plans to serve children in families at differen income levels.

States operating Medicaid programs—including SCHIP Medicaid-expansions—must offer the same benefit package to SCHIP beneficiaries as they do to Medicaid beneficiaries.[10] These benefits include the Early a

[9]This waiver authority for seriously ill children was inspired by the case of a ventilator dependent child, Katie Beckett. Katie's mother successfully argued that the nursing services her daughter required could be provided in her home and at a cost less than that providing the same care in a hospital. What resulted was the so-called "Katie Beckett Waiver," enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982.

[10]A state that chooses a stand-alone or combination SCHIP program may introduce limite cost sharing and base its benefit package on one of several benchmarks specified in the statute, such as the Federal Employees Health Benefit program, or state coverage. See 42 U.S.C. §1397cc(a) and (b) and U.S. General Accounting Office, *Children's Health Insurance Program: State Implementation Approaches are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999).

Periodic Screening, Diagnostic and Treatment (EPSDT) provision that requires states to provide children and adolescents under age 21 with access to comprehensive, periodic evaluations of physical and mental health and developmental and nutritional status, as well as vision, hearing, and dental needs. States must provide all services needed for conditions discovered through these routine pediatric screenings regardless of whether the service is covered by the state Medicaid plan for other beneficiaries. In 2000, more than 1 million children were enrolled in SCHIP Medicaid expansion programs and were, therefore, eligible for EPSDT screens.

While No Formal Tracking Occurs, Available Estimates Indicate That Many Children—Primarily Adolescent Males—Were Placed with the State to Access Mental Health Services

State child welfare and county juvenile justice officials estimated that parents in their jurisdictions placed over 12,700 children in fiscal year 2001, generally adolescent males, in child welfare and juvenile justice agencies so that the children could receive mental health services. Nationwide, this number is likely higher because officials in 32 states, including the 5 states with the largest populations of children, did not provide us with estimates. Moreover, we surveyed juvenile justice officials in only 33 counties and three did not provide estimates. Only estimates were available because no federal or state agency tracked children placed to obtain mental health services in a formal or comprehensive manner. Officials in the 6 states we visited reported that placed children came from families of all financial levels and said that the seriousness of the children's illnesses strained families' abilities to function.

Some Officials Estimate That Parents Placed Over 12,700 Children to Access Mental Health Services

State child welfare officials and county juvenile justice officials estimated that over 12,700 children entered the child welfare or juvenile justice systems in order to receive mental health services in fiscal year 2001. Of these children, about 3,700 entered the child welfare system. State child welfare officials reported estimates that ranged from 0 to 1,071 children, with a median of 71. Table 2 provides detailed information about the estimated number of children placed in the child welfare system. County juvenile justice officials reported estimates that totaled to approximately 9,000 children and ranged from 0 to 1,750, with a median of 140. Table 3 provides details on the estimated number of children placed in the juvenile justice system.

Table 2: States' Estimated Number of Children Placed in the Child Welfare System to Obtain Mental Health Services in Fiscal Year 2001

State	Number of children placed
Alaska	[a]
Alabama	130
Arkansas	[b]
Arizona	[b]
California	[c]
Colorado	[c]
Connecticut	738
District of Columbia	[d]
Delaware	0
Florida	[d]
Georgia	[d]
Hawaii	[d]
Iowa	[b]
Idaho	123
Illinois	[a]
Indiana	0
Kansas	[d]
Kentucky	14
Louisiana	[a]
Massachusetts	[c]
Maryland	54
Maine	[b]
Michigan	[c]
Minnesota	1,071
Missouri	[d]
Mississippi	13
Montana	[d,b]
North Carolina	440
North Dakota	[b]
Nebraska	[c]
New Hampshire	[d]
New Jersey	[c]
New Mexico	[c]
Nevada	20
New York	[c]
Ohio	[b]
Oklahoma	3
Oregon	101
Pennsylvania	71
Rhode Island	279
South Carolina	[a]

State	Number of children placed
South Dakota	[b]
Tennessee	[b]
Texas	[d]
Utah	[b]
Virginia	[b]
Vermont	60
Washington	423
Wisconsin	[c]
West Virginia	135
Wyoming	5
Total	**3,680**

Source: GAO survey

[a]State did not respond to our survey.

[b]State did not provide the data requested, but indicated that voluntary placement happens.

[c]State did not provide the data requested.

[d]State officials said the practice of voluntary placement is not legal in the state.

Table 3: Estimated Number of Children Placed in the Juvenile Justice System in 33 Counties to Obtain Mental Health Services in Fiscal Year 2001

State	County	Number of children placed
Arizona	Maricopa	60
Arizona	Pima	1,750
California	Los Angeles	*
California	San Diego	200
Colorado	El Paso	40
Colorado	Jefferson	100
Florida	Broward	0
Florida	Miami-Dade	999
Georgia	Fulton	172
Georgia	Gwinnett	100
Illinois	Cook	0
Illinois	DuPage	35
Indiana	Lake	600
Indiana	Marion	100
Louisiana	Jefferson Parish	50
Michigan	Oakland	160
Michigan	Wayne	400
New Jersey	Bergen	*
New Jersey	Middlesex	999
New York	Brooklyn	74
New York	Queens	49
Ohio	Cuyahoga	*
Ohio	Franklin	363
Pennsylvania	Montgomery	20
Pennsylvania	Philadelphia	500
Texas	Dallas	200
Texas	Harris	200
Virginia	Fairfax	350
Virginia	Prince William	840
Washington	King	575
Washington	Pierce	0
Wisconsin	Dane	120
Wisconsin	Milwaukee	0
Total		9,056

Source: GAO survey.

* County did not provide an estimate of the number of children.

Nationwide, the number of children placed is likely to be higher. Eleven states reported that they could not provide us with an estimate of child welfare placements solely to obtain mental health services even though

they were aware that such placements occurred. Moreover, officials in 9 additional states that responded to our survey did not provide an estimate and did not mention whether or not parents turned to the child welfare system to access mental health services. However, child welfare workers we interviewed in 2 of these 9 states—California and New Jersey—told us that these placements did in fact occur. Although some of the state child welfare officials that we visited in California said children do not enter that system to obtain mental health services, county child welfare workers said that they knew of such placements and explained how the cases were coded in their system. Four states did not respond to the survey.[11] Information on the prevalence of children present in the juvenile justice system is also limited in this statement since we surveyed only 33 counties. In 3 of those counties, juvenile justice officials reported that while they did not have an estimate to provide, they knew that children were entering the system to obtain mental health services because they were not able to access such services in other ways.

Federal and state systems that track children in the juvenile justice and child welfare systems do not formally or comprehensively track children placed to receive mental health services. For example, ACF's AFCARS, which contains data reported by states about children in foster care or adopted out of foster care, does not have a data element that identifies this population. Similarly, every 2 years OJJDP conducts the Census of Juveniles in Residential Placement, which gathers information on children in juvenile residential facilities and their characteristics but no data base variable exists to isolate children whose parents sought the help of the juvenile justice system to meet children's mental health needs from other children in the juvenile justice system who may also have mental health problems. OSERS maintains extensive data about children who receive special education services, but data are aggregated at the state level and do not include information about who has custody of the child.

Officials Said Placed Children Were Mostly Adolescent Males with Severe Mental Health Problems

According to our survey of state child welfare directors, placed children are more likely to be boys than girls and are more likely to be adolescent. Child welfare directors in 19 states reported that, in fiscal year 2001, 65 percent of placed children were male and 67 percent were between the ages of 13 and 18. While juvenile justice officials did not provide information about the gender and ages of children placed in their system,

[11]These four states were Alaska, Illinois, Louisiana, and South Carolina.

children in the juvenile justice population are mostly male and range in age from 13 to 18.[12]

The officials from state and county child-serving agencies and parents we interviewed in the 6 states that we visited said that children who were placed had severe mental illnesses, sometimes in combination with other disorders, and their parents believed they required intense treatment that could not be provided in their homes. Many of these children were violent and had tried to hurt themselves or others, and often prevented their parents from meeting the needs of the other children in the family. For example, in Maryland, officials told us about a teenage boy who was mentally ill, developmentally disabled, autistic,[13] and hospitalized. Because the boy was both violent and sexually aggressive, the county told his mother that if she brought him home from a stay in the hospital, they would remove her other children from the house. Caring for children with severe mental illness can also prevent parents from obtaining full-time work or cause disruptions in their work lives. For example, an Arkansas parent now raising her grandchild does not work because of the time necessary to care for her mentally ill granddaughter. State and county officials from child-serving agencies in 5 of the 6 states that we visited told us that finding placements for children who were mentally ill and who also had other developmental disabilities was particularly difficult. Children who are placed or are at risk of placement come from families that span a variety of economic levels. However, officials from state and county child-serving agencies in all 6 states that we visited said children from middle class families are more likely to be placed because they are not eligible for Medicaid and their families do not have the funds to pay for treatments not covered by insurance.

Multiple Factors Influence Decisions to Place Children

Multiple factors influence parents' decisions to place their children in the child welfare and juvenile justice systems so that they can obtain mental health services. Private health insurance plans often have gaps and limitations in the mental health coverage they provide, and not all children

[12]In commenting on a draft of our April 2003 report, DOJ said that, in the absence of formal tracking and official data, describing with any certainty the characteristics of youth placed voluntarily by their parents in the juvenile justice system is impossible.

[13]Autism is a developmental disability typically affecting the processing, integrating, and organizing of information that significantly impacts communication, social interaction, functional skills, and educational performance.

covered by Medicaid received needed services. Even when parents could afford mental health services, some could not access services at times when they needed those services because supplies of such services were inadequate. In other instances, some mental health agencies and schools have limited resources to provide mental health services and are required to serve children with a mental illness in the least restrictive environment possible—which can limit the alternatives available to parents who believe their children need residential placements. In other instances, parents sometimes have difficulty obtaining all needed services for their children in their communities because eligibility requirements for services provided by various agencies differ. Furthermore, some officials and service providers have misunderstood the role of their own and other agencies and, therefore, gave parents inaccurate or incomplete information about available services for families. These misunderstandings created gaps in services for some children.

Limitations in Private and Public Insurance Often Restrict Access to Mental Health Care, and Some Services are Limited

Almost all state child welfare directors and county juvenile justice officials who responded to our surveys reported that private health insurance limitations were increasing the number of child welfare and juvenile justice placements to obtain mental health services, and well over half reported Medicaid rules also increased such placements. For example, according to parents and state and local officials in all 6 states that we visited, many private insurance plans and separate SCHIP plans offered limited coverage for traditional or clinical treatments, such as psychotherapy or psychiatric consultations,[14] and did not cover residential treatment placements. In addition, state officials in 3 of the 6 states we visited said that Medicaid rules in some states that require the preauthorization of services could result in delays and denials of community-based services.

The legislatures in the 6 states that we visited passed health insurance parity laws to increase the coverage that was available for mental health services by requiring insurance companies to provide mental health coverage that was comparable to what they offered for physical health care. Although these laws met or exceeded the standard established by the federal MHPA, they did not require private plans to cover intensive, long term, and nontraditional services such as respite care and wrap-around

[14]These services are generally provided by licensed or certified psychiatrists, psychologists, or masters-level social workers.

services.[15] Mental health officials and service providers in the states that we visited said these services were often necessary to help families maintain children with a severe mental illness in their homes. Furthermore, federal law preempts states from directly regulating self-funded, employer-sponsored health insurance plans and in doing so exempted many families from protection under state laws.

In the 6 states that we visited, state and local mental health officials agreed that Medicaid had far fewer restrictions and limitations than private health insurance plans. In addition, mental health officials in Arkansas, California, and Maryland told us that differences between private insurance and Medicaid programs had created two distinct systems of child mental health services. Under these systems, children covered by Medicaid had greater coverage for mental health services than children covered by private insurance.

All 6 of the states that we visited covered optional Medicaid and SCHIP services by expanding their programs for children with mental illness who were ineligible for Medicaid on the basis of their families' income. These included the HCBS waivers, Katie Beckett option, Rehabilitation option, and SCHIP programs.

For example, states used different approaches to expand Medicaid coverage. Medicaid officials in Kansas received permission from CMS to implement a HCBS waiver to expand coverage for community-based mental health services for a limited number of children who are chronically mentally ill. Although Medicaid officials in New Jersey financed its new child mental health system through a Medicaid Rehabilitation option, the option extends Medicaid coverage to only a limited number of children who have exhausted benefits under other insurance and who have chronic and severe mental illness. This option generally provides 60 days of community-based services and limited hospitalization.[16] Arkansas, Maryland, and Minnesota used Medicaid's

[15]Respite care refers to the supervision of mentally ill or other disabled children by a trained caretaker for brief periods of time in order to provide parents relief from the strain of caring for a child with serious mental illness. Wrap-around services encompass a variety of community supports, including counseling, mentoring, tutoring, and economic services that are designed to meet the individual needs of children and their families.

[16]In commenting on a draft of our April 2003 report, a Kansas official said that the state had expanded the services the state provides under the Rehabilitation option and does not limit the services to 60 days, but bases services on the individual clinical and medical needs of the child.

Katie Beckett option to expand Medicaid coverage to physically or mentally disabled children who meet CMS's requirements for institutional care. Arkansas' program did not require parents to pay into the program to receive services, but Minnesota's program required parents to pay according to their ability as defined by a sliding scale.

Although Medicaid's EPSDT provision requires Medicaid coverage for all necessary physical and mental health services that are identified during routine periodic screening as long as the treatment is reimbursable under federal Medicaid guidelines, some state officials said many eligible children are unable to access necessary services through Medicaid because practitioners in the states implement EPSDT unevenly. For example, a Medicaid official in Maryland told us that the implementation of EPSDT varied from county to county. Medicaid officials in California said implementation varied from practitioner to practitioner although access to EPSDT services was increasing as a result of litigation. These officials explained that some practitioners are reluctant to recommend services if such services are not available, some do not have the time to question parents about their child's mental health, and others are not well informed about children's mental health issues. In a July 2001 report, we recommended that the Administrator of CMS work with states to develop criteria and timelines for consistently assessing and improving EPSDT reporting and provision of services.[17] As we stated in that report, comprehensive national data on the implementation of EPSDT are needed to judge states' success in implementing EPSDT requirements.

Low Medicaid reimbursement rates may restrict the participation of some practitioners and thus further restrict services. In all 6 states, officials from a variety of agencies said Medicaid rates for some services are lower than the usual and customary rates in their areas and, in some areas, psychiatrists and psychotherapists will not accept Medicaid patients or expand the number that they are presently seeing because of low Medicaid reimbursements. For example, a psychologist in Minnesota told us that Medicaid reimbursement for a psychotherapy session is about half the customary rate, and a mental health official in New Jersey said that Medicaid reimburses only $5 per visit for monitoring the use and effects of psychotherapeutic medication.

[17]U.S. General Accounting Office, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

Even when insurance covered the costs of mental health services, some mental health officials and parents indicated all parents could not access services or placements in their community because the supplies of these services were limited. Fifteen of the 28 child welfare officials and 9 of the 23 juvenile justice officials who responded to our survey question on the relationship between community mental health services and voluntary placements indicated that the lack of such services increased voluntary placements. In every site we visited, officials of state and local child-serving agencies and parents reported inadequate supplies of mental health service providers and specialized mental health placements. Many of these officials said that shortages of child psychiatrists, child psychologists, respite care workers, and behavior therapists existed on statewide levels and were worse in rural areas. Also, specialized, out-of-home mental health placements, such as psychiatric in-patient services and residential treatment facilities, were often not available or had long waiting lists. For example, Arkansas officials said that the state has no state-run psychiatric hospital placements for children under age 12, and, in California, some children have to wait about 8 months for a residential placement. Officials in 3 states noted that relatively fewer residential placements are available for girls than are available for boys and that few placements would accept children with histories of arson and sexual aggression. Moreover, these officials noted children placed in the child welfare or juvenile justice systems received preference for services, particularly when the services were court-ordered.

Difficulties Accessing Services through Certain Agencies, Difficulties in Meeting Service Eligibility Requirements, and Misunderstandings among Officials and Service Providers Can Influence Placements

In the 6 states that we visited, limited resources in mental health agencies and public schools to fund mental health services and agency officials' attempts to minimize the use of residential services posed additional challenges for parents seeking services and placements for their children. In addition, some children who needed multiple supports experienced gaps in services because of differences in the eligibility requirements for obtaining such services. Moreover, some officials and service providers often misunderstood the responsibilities and resources of their own and other agencies and communicated the misunderstandings to parents, compounding service gaps and delays.

Difficulties Accessing Services through Mental Health or Education Agencies

According to some mental health and education officials, budgetary shortfalls in the 6 states that we visited contributed to agencies' attempts to cut or control costs, including the cost of mental health services. Mental health agencies used a variety of strategies to control costs, such as reducing spending, requiring that services covered by Medicaid be approved before they are provided, and limiting the number of children

served. In each state we visited, some parents believed the strategies affected the quality of the services their children received and created unnecessary delays in getting services. In Arkansas, private, nonprofit mental health providers that contract with the state to provide community mental health said that state officials cut their funding and, as a result, they had to reduce the length of treatment sessions and increase the length of waiting lists. In Arkansas, Maryland, and New Jersey, state officials said that they contracted with private, nonprofit agencies to authorize the medical necessity of mental health services covered by Medicaid. Arkansas required preauthorization of all Medicaid-financed mental health services, including those that were legally required, such as the screening of foster children for mental health services. A variety of officials in this state and a parent reported that the preauthorization agency often denied services for children because they had not benefited from similar services in the past. For example, this parent said the preauthorization agency refused her son's therapist's request to hospitalize him to treat his suicidal behavior because past hospitalizations for suicide attempts had not reduced the behavior. In New Jersey, state mental health officials reduced the number of counties that had been targeted to implement the state's new child mental health system and limited the number of children served by the system. For example, officials from a variety of county agencies reported that the new system of care limited the number of children receiving the highest level of care in their county to 180 a year, although juvenile justice officials said that at least 500 children in their system alone needed such services. Officials from child welfare, mental health, and juvenile justice agencies said eligible children who did not receive the highest level of care were placed on waiting lists and provided less intensive services.

Officials from a variety of county agencies and some parents also reported that public schools in their county—in order to control costs—were often reluctant to provide individualized mental health services for special education children beyond services that are routinely available. For example, child welfare officials in 3 locations we visited said schools fit children with a mental illness into preexisting programs, and school officials in two of these locations agreed, stating that children's IEPs could only contain services that were available in the schools. Almost all the parents that we interviewed said that school officials were reluctant to evaluate their children to determine eligibility for special education services or provide specialized services for them. For example, a parent of a child with a mental illness in Kansas said officials in her daughter's school refused to evaluate the child for a year and a half. After the evaluation, the school recommended that the child work with a learning

disability specialist for 30 minutes a week, even though the parent said this service was insufficient and did not address her daughter's destructive, violent, and aggressive behavior.

As a result of the difficulties encountered at both mental health agencies and schools, some parents could not access the community-based services they needed to care for their child at home nor place their child in a residential treatment facility. In 4 of the 6 states that we visited, some teachers and mental health service providers encouraged parents to refuse to bring their child home from a hospital or other supervised placement, such as a detention center, when they were informed their child was being discharged in order to obtain mental services from child welfare agencies. Although these parents realized they were abandoning their child and, as a result, could be arrested and lose custody, they believed that this was the only alternative that remained to obtain services. Some parents that we interviewed told child welfare workers they would physically abuse their child in their presence to force them to place the child in their system if they could not get help for their child any other way, and juvenile justice officials told us other parents asked the police to arrest their children. However, officials in 2 of the states that we visited said children often remain hospitalized for months without appropriate services because child welfare agencies did not have the resources to provide the needed level of services or specialized placement, could not obtain resources from other agencies, or could not access appropriate services or placements that had the capacity to treat another child. In addition, although federal law does not require custody relinquishment to obtain mental health services, state child welfare officials in two states that we visited said that their state required parents to relinquish custody of their child to the state after the voluntary placement period ends. In one state, these officials misconstrued federal requirements and believed that they required relinquishment and in the other state, officials said relinquishment enabled them to have more control over the child's care.

Difficulties Meeting Eligibility Requirements for Mental Health Services

Eligibility requirements for obtaining mental health services pose several challenges for parents. For example, state and local Medicaid officials in 3 states told us that some children lose their eligibility for Medicaid-funded services because their families' income increased beyond Medicaid's threshold or move in and out of eligibility as their families' income fluctuates. Also, some child welfare officials said some children receive Medicaid because they are in foster care and lose their eligibility when they return home if the family is not eligible. Alternatively, juvenile justice officials in 6 states said that children in juvenile justice correctional or

detention facilities lose Medicaid eligibility and have to reapply to resume coverage when they are released from the facility.

In addition, in all 6 of the school districts we visited, schools used different eligibility criteria for mental health services than mental health or other child-serving agencies in their area. For example, school officials in 4 districts told us that some mentally ill children are not eligible for mental health services through their special education programs because they were making adequate educational progress or because behavior problems—rather than mental illness—prevented them from making adequate progress. However, mental health officials who work with children attending some of these schools reported that schools often have a narrow definition of educational progress and do not recognize that inappropriate behavior might be a symptom of mental illness. For example, a parent of a child with attention deficit[18] and bipolar[19] disorders said her son's school refused to provide special education services for him because his lack of educational progress was due to his failure to pay attention and to get his work done, rather than his mental illness, and a parent of a bipolar, schizophrenic[20] son said school officials told her that she was responsible for her son's behavior and poor school performance.

Although a variety of officials said schools had more restrictive eligibility requirements for mental health than other child-serving agencies, school officials in a county in California said that their county mental health agency used a more restrictive definition than the schools. In California, state law required that county mental health agencies treat children covered by Medicaid and SCHIP who were diagnosed as SED or who were eligible for special education services.[21] California also requires that children be evaluated by county mental health agencies and fit a statutory definition of SED. School officials said that these children get priority and their services consumed all available county child mental health resources. According to these officials, other children, including children

[18]Attention deficit disorder is a syndrome characterized by serious and persistent difficulties in attention span, impulse control, and, sometimes, hyperactivity.

[19]Bipolar disorder is characterized by the occurrence of one or more major depressive episodes accompanied by at least one manic episode over a brief time interval.

[20]Schizophrenia is a cluster of disorders characterized by delusions, hallucinations, disordered thinking, and emotional unresponsiveness.

[21]The California legislature transferred the responsibility for providing mental health services to children in special education from schools to counties in the late 1980s.

with dual diagnoses of mental illness and substance abuse, mental retardation, or autism-related disorders and children without the required diagnoses have to wait for county mental health services or might not receive services at all, although some may receive services through their school guidance counselors or social workers.

Misunderstandings of Agencies' Responsibilities and Resources

Program officials' and service providers' misunderstandings of agencies' responsibilities and resources also affect service provision. For example, misunderstandings about Medicaid coverage created gaps and delays in services. In 3 states, some state and county officials did not know the Katie Beckett option could expand Medicaid coverage for children with a mental illness regardless of family status. In one of these states, a parent told us that county Medicaid officials incorrectly told her that her son wa ineligible for coverage under this option because he had a two-parent family. In 2 other states, county mental health officials erroneously told u that this option applied only to children with very severe medical conditions. In another state, a Medicaid official did not know that childre enrolled in SCHIP Medicaid expansion programs were eligible for EPSDT services. Furthermore, state child welfare officials in 2 states and mental health workers in a third did not know Medicaid's EPSDT provision includes mental health screenings, diagnosis, and treatment and thought the provision covered only physical health services.

In all 6 states, some parents, a variety of state and local officials, mental health service providers, caseworkers, and judges misunderstood the rol and responsibilities of schools in implementing IDEA. For example, some parents we interviewed in 5 of these states said that their children waited over a year to receive special education services because they and the mental health professionals they worked with did not understand the procedures IDEA required schools to follow. For example, some parents were told that referrals for special education had to be in writing. Also, some parents and professionals misunderstood that IDEA gives all eligibl children, including children with a mental illness, the right to a free appropriate education and parents did not know that they could appeal a school's decision about providing special education services. For exampl a parent in Kansas agreed to home-school her 10-year old, sexually aggressive, child with a mental illness because the school would not put the child in a setting that would ensure the safety of his classmates. Despite her long-term involvement with a community mental health agency, this parent believed home schooling was her child's only option.

States Have Developed a Range of Practices That May Reduce the Need for Some Mental Health-Related Child Welfare and Juvenile Justice Placements

Although few strategies were developed specifically to prevent mental health-related child welfare and juvenile justice placements, state and local officials identified a range of practices that they believe may prevent such placements by addressing key issues that have limited access to child mental health services in their state. State and local practices focused on three main areas: finding new ways to reduce costs or to fund services, consolidating services in a single location, and expanding community mental health services and supporting families. Although some programs were modeled on practices that had been evaluated in other settings, the effectiveness of the practices is unknown because many of them were implemented on a small scale in one location or with a small target group or were too new to be rigorously evaluated.

Finding New Ways to Reduce Costs or to Fund Services May Help Agencies Pay for Mental Health Treatment

According to officials in the 6 states that we visited, one way to reduce the cost of services is to better match children's needs to the appropriate level of service. One goal of some of the programs we reviewed was to ensure that children with lower-level needs were served with lower-level and less expensive services, reserving the more expensive services for children with more severe mental illnesses. Under New Jersey's Systems of Care Initiative, the state contracted with a private, nonprofit organization for a variety of services, such as mental health screenings and assessments to determine the level of care needed, authorization of service, insurance determination, billing, and care coordination across all agencies involved with the children. When the Initiative is fully implemented statewide, the contractor in each county will use standardized tools to assess children's mental health and uniform protocols to determine appropriate levels of care. Children requiring lower levels of care will be referred to community-based providers, while children requiring a higher level of care will be approved to receive services from local Care Management Organizations specifically created to serve them. Presently, the System of Care Initiative has been implemented in 5 of the state's 21 counties.

As another cost-saving method, some programs substituted expensive traditional mental health providers with nontraditional and less expensive providers. Many state and local officials we interviewed in 5 of the states we visited told us that the historic way to treat children with a mental illness included psychiatrists and residential placements. However, officials in New Jersey, Kansas, and Minnesota said their states had switched their focus to using less expensive providers such as using nurses to distribute medicines instead of psychiatrists or nontraditional bachelors-level workers for case management instead of masters-level social workers. For example, Uniting Networks for Youth—a private,

county-based provider in Minnesota—used two commercially available, highly structured programs that allowed them to substitute lower-credentialed bachelor-level staff under the supervision of a masters-level clinician as the primary service provider instead of using higher-level clinicians. County officials told us this structured program has many safeguards, including the collection of extensive data from providers, teachers, and families that allow masters-level clinicians to review the appropriateness and effectiveness of provided mental health services.

In addition to reducing the cost of services, state officials in all 6 states identified the blending of funds from multiple sources as another way to pay for services, thus working around agencies' limitations on the types of mental health services and placement settings each can fund. For example, in a county in Maryland, a local Coordinating Council blends funds from multiple agencies to provide community-based services to children with a mental illness involved with the judicial, child welfare, and mental health systems and with district special education programs. The Council, headed by a judge, leveraged funding by inviting key decision makers—those who could commit resources—from a variety of child-serving agencies and organizations, including the local departments of social services and juvenile justice, the public defenders office, prosecutors, attorneys, and Catholic Charities, to serve on the Council.

In addition to blending funds to pay for services, state officials in 4 of the 6 the states that we visited identified the use of flexible funds, with few restrictions, to pay for nontraditional services that are not generally allowable under state guidelines. For example, Arkansas's Together We Can Program used flexible funds from a federal Social Services Block Grant, state general revenue, and the Title IV-B program to provide a wide array of nontraditional supportive services, such as in-home counseling, community activities, respite care, mentoring, tutoring, clothing, and furniture that helped the family care for the child at home and supported the child in his community.

Bringing Mental Health Services into a Single Location May Improve Access

To improve access to mental health services and bring clarity to a confusing mental health system, 3 of the states that we visited developed a facility to be a single point of entry into the mental health system. Typically, several agencies are represented at the facility and children are assessed with a common instrument and eligible for the same services regardless of what agency had primary responsibility. Kansas's Shawnee County Child and Family Resource Center is a one-stop facility and, according to state mental health officials, a model for the rest of the state.

The center houses workers from 11 social services agencies, including mental health, child welfare, juvenile justice, and education. All children with mental health needs, regardless of which agency first encountered the child, are referred to the center. Case managers at the Center assess the child's psychological, educational, and functional needs, determine appropriate services and placements, make referrals, provide direct counseling services, and determine how to pay for services. The facility includes four bedrooms for children who need to be removed from their homes for short periods of time and a secure juvenile justice intake suite that is staffed 24 hours a day.

State officials in all 6 of the states that we visited also identified co-locating services in public facilities such as schools and community centers as another way to improve access. In Harford County, Maryland, for example, mental health services are collocated at an elementary school specifically to improve access to care for students with a mental illness. Using county health and mental health funds, the school developed an in-house mental health clinic that provides mental health services through a bachelors-level social worker, a nurse practitioner, and consultative services from a physician and a psychiatrist. In addition, the school has a variety of internal support staff available to children with a mental illness, including a guidance counselor, a behavior specialist, a home visitor who supports families and assesses the home situation, and a pupil personnel worker who visits homes and helps with transportation issues. The school has several programs available to children with a mental illness, including an intensive, in-school program staffed with a full-time school psychologist; a mentoring program that is run by paid school staff, high school students, and volunteer community members; a program that provides counseling, tutoring, recreation, social skills groups, home visits, referrals, and some psychiatric rehabilitation services; a program to identify elementary school children with a mental illness and increase their access to services; and two collaborative programs with contracted mental health providers that provide community support and prevention services and intensive case management services.

Expanding Community Mental Health Services and Supporting Families May Improve Treatment for Children with a Mental Illness

Officials from child-serving agencies in all 6 states we visited identified the expansion of the number and range of community-based services to provide an entire continuum of care as a way to improve treatment for children with a mental illness. Some programs we reviewed developed a complete range of community-based mental health services for children, including early intervention, diversion,[22] transitional services, and crisis intervention. In addition, some programs supported families of children with a mental illness and encouraged parent involvement in their children's care. Examples of these programs follow.

Early Intervention: Working with local hospitals, workers from the Family Service and Guidance Center in Shawnee County, Kansas, screen newborns in local hospitals. If babies appear at-risk, social workers conduct home visits and refer families to health care professionals or others for support. The Center also developed a therapeutic preschool practice directed at 3-5 year old children, with or without a mental illness diagnosis, who were likely to need special education services when they entered kindergarten. The program serves 32-36 children and provides a half-day of services.

Diversion: Los Angeles' Juvenile Alternative Defense Effort (JADE) was designed to prevent or reduce the time of expensive juvenile justice placements for youths with mental illness, by arranging assessments, providing referrals to mental health providers and advocating for these youth to ensure they receive the treatment they need. Upon referral to JADE, a psychiatric social worker performs an extensive psychosocial evaluation, including a developmental history, family history, and educational history that includes failures and successes, delinquency behaviors, and a mental health status exam. Based on the evaluation, the social worker makes placement and service recommendations to the juvenile court judge. JADE officials said that the evaluations and recommendations give the judges the information they need to consider alternatives to incarceration.

Transitional Services: State and county juvenile justice and mental health officials in all 6 states we visited stressed the importance of including transitional services in a continuum of care. These services are typically provided to a child leaving a residential setting and returning to

[22]Diversion programs attempt to prevent or reduce the time children spend in inappropriate placements.

his or her home or community. For example, Minnesota's Red Wing facility is a secure juvenile justice facility that provides in-house mental health services and places a strong focus on transitional services so youth can successfully reenter their own community. The transition program is designed with various levels that allow youth who exhibit good behavior to move to lower levels of supervision. For instance, at level 4, youth begin to transition back to the community by making periodic visits to their homes. At level 5, youth move to a transitional living unit at Red Wing that focuses on applying new skills to activities in their homes and communities. After youth leave Red Wing, a county juvenile justice worker monitors them for 90 days.

Crisis Intervention: Programs we reviewed in 4 states had a mobile crisis unit consisting of teams of staff that visit homes to stabilize crisis situations. Funding, staffing, and authority of these teams vary. Some of the crisis teams can provide direct mental health services; others conduct assessments and make emergency petitions to psychiatric hospitals on behalf of the family. One of the difficulties noted by program officials is determining how to pay for crisis services since these services may not be covered by insurance and families may not have the ability to pay. In Harford County, Maryland, the mobile crisis team is not a fee-for-service provider but is funded by a grant. The team—a psychiatrist, a psychologist, and a licensed social worker—provide direct mental health services and are authorized to make emergency petitions to get a child with a mental illness admitted to a hospital psychiatric unit.

A second way some states improve treatment for children with a mental illness is to provide services to support families and encourage parental involvement in their child's care. State and local officials in all 6 states pointed out that involving parents was a fundamental change in philosophy. Previously, services were provided solely to the children and parents were not included in the decisions about their child's care. Now, the focus is on providing the services parents need to maintain the child in the home and helping parents make informed decisions about their child's care. For example, The Sycamores, a residential mental health facility in Los Angeles County, California, works extensively with parents of children with severe mental illness at its facility and requires their participation. The Sycamores also provides a variety of supportive services, including household items and services such as transportation to and from the facility. In addition, as part of its transitional program, The Sycamores uses Therapeutic Behavioral Services (TBS), one-on-one services provided whenever needed 24 hours a day, 7 days a week to assist youth in

maintaining their current living situation and in developing the coping and problem-solving skills needed.

Concluding Observations

Some parents are placing their children, mostly adolescent boys with severe mental illness, in the child welfare and juvenile justice systems to access mental health services. Although these children may not have been abused or neglected, or may not have committed a criminal or delinquent act, parents are turning to these agencies because they see no alternatives for obtaining comprehensive services for them. Because federal, state, and local agencies do not systematically track these children, the extent and outcomes of these placements are not fully known. To determine the extent to which children may be placed inappropriately in the child welfare and juvenile justice systems in order to obtain mental health services, we recommended in our April 2003 report that the Secretary of HHS and the Attorney General investigate the feasibility of tracking these children to determine the extent and outcomes of these placements. In commenting on a draft of that report, DOJ agreed that tracking should take place, but only in the short term, and that HHS should take the lead in such an effort. HHS said that asking agencies to track this population does not address the lack of mental health resources for families and communities and does not address the problems of the children and their families. However, we believe that knowledge of the extent of this practice is a necessary first step to determine what corrective actions might be taken and may be useful in identifying which progressive practices will most benefit these children.

Experts, agency officials, and service providers agree that agencies must work together to meet the needs of children with severe mental illness because these children have complex problems and are likely to need services from multiple agencies if they are to remain in their communities or if they are to successfully transition from a residential facility back to their communities. However, in some cases, state and local officials' misunderstandings of each agency's service requirements, responsibilities, and resources prevent the provision of interagency services that have the potential to address the needs of these children and their families. In our April 2003 report, we recommended that the Secretaries of HHS and Education and the Attorney General develop an interagency working group (including representatives from CMS, SAMHSA, and ACF) to identify the causes of these misunderstandings and to create an action plan to address those causes. All three agencies said they would participate in any interagency working group that might be established based on our recommendation and DOJ recommended using the existing

Coordinating Council on Juvenile Justice and Delinquency Prevention for the purposes we stated. We believe several organizational entities may be appropriate and that the member agencies forming this group should determine the entity that is best suited.

Although states and counties are implementing practices that may reduce the need for parents to place their children with child welfare or juvenile justice agencies, many of the programs are new, small, and only serve children in specific localities. Furthermore, their effectiveness in achieving their multiple goals—such as reducing the cost of mental health services, supporting families, and helping children overcome their mental illnesses—has not yet been fully evaluated. Given that states and localities are developing new approaches to meeting the needs of children with mental illness, it is important that the federal government continue its role in supporting evaluations of these programs and disseminating the results. To further such efforts, we recommended in the report that the agencies continue to encourage states to evaluate the child mental health programs that the states fund or initiate. In commenting on a draft of our April 2003 report, Education said that no recommendations were made for increased grant spending to duplicate or disseminate the positive features of the practices we highlighted. As a result, we added a recommendation that the Secretaries of HHS and Education and the Attorney General determine the most effective means of disseminating the results of these and other available studies to state and local entities.

Madam Chairman, this concludes my prepared statement. I would be pleased to respond to any questions that you or other members of the Committee may have.

GAO Contact and Acknowledgments

For further contacts regarding this testimony, please call Cornelia M. Ashby at (202) 512-8403. Individuals making key contributions to this testimony include Diana Pietrowiak and Kathleen D. White.

Related GAO Products

Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services. GAO-03-397. Washington, D.C.: April 21, 2003.

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